Navigating Hospital-Physician Subsidy Arrangements

Examine hospital-based specialist compensation

By Tynan Kugler, MBA/MPH, CVA

Subsidies paid by hospitals to medical providers have evolved in response to changes in the healthcare landscape. The nature of these subsidies can vary widely, and they are often impacted by regulatory requirements, market dynamics, and the goals of the parties involved. Careful reviews of subsidies are essential for maintaining regulatory compliance, ensuring financial integrity, preventing fraud and abuse, and enhancing transparency and accountability.

A subsidy, in the context of this article, refers to financial assistance provided by hospitalts or health systems to private medical practices (i.e., providers). The assistance is intended to help providers maintain necessary infrastructure and provide essential medical care to their communities.

Many hospital-based specialties, such as anesthesiology, radiology, pathology, emergency medicine, and hospital medicine, face a challenge. The revenue these providers can generate may not cover both the cost to provide the services and compensation reflective of fair market value and commercial reasonableness. This is largely due to the mix of patients hospitals are contractually required to treat.

Background

Subsidies to medical providers can vary widely depending on the healthcare system and the specific arrangement between a hospital and a provider. They have historically supported medical providers residing in underserved areas, those with unfavorable payer mixes, or for specific specialties. Today, subsidies to private providers continue to be prevalent, even as more hospitals employ physicians directly or enter into other types of affiliation arrangements with providers.

While subsidies can help support medical providers financially, they must comply with regulatory requirements, specifically the Physician Self-Referral Law (i.e., Stark law) and the federal anti-kickback statute, which regulate financial relationships between hospitals and physicians. These laws restrict hospitals from providing compensation that could be seen as inducements for physician referrals unless certain exceptions or safe harbors are satisfied.

Stark law (42 CFR § 411.351) definitions

Fair market value means "the value in an arm's-length transaction, consistent with the general market value of the subject transaction."

With respect to compensation for services, *general market value* means "the compensation that would be paid at the time the parties enter into the service arrangement as the result of bona fide bargaining between well-informed parties that are not otherwise in a position to generate business for each other."

A "commercially reasonable" arrangement "furthers a legitimate business purpose of the parties to the arrangement and is sensible, considering the characteristics of the parties, including their size, type, scope, and specialty. An arrangement may be commercially reasonable even if it does not result in profit for one or more of the parties."

Factors Impacting Subsidies

No Surprises Act

The No Surprises Act (Act), enacted in December 2020, aims to protect patients from unexpected medical bills resulting

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from out-of-network care in emergencies, scheduled care at in-network facilities where out-of-network providers are involved without the patient's knowledge, and air ambulance services. While the Act primarily targets billing practices, its implementation can also have broader implications for hospital-based specialties regarding network negotiations, provider networks, and administrative burdens.

Network negotiations – The Act strives to limit the amount a patient pays out of pocket to be more consistent with an in-network amount. Hospital-based specialties often rely on out-of-network billing practices, and the Act can change how these specialties negotiate rates with insurers. Also, specialties that previously relied on out-of-network billing for a significant portion of their revenue may experience reduced revenue or even financial losses.

Provider networks – Hospitals and health systems may need to reassess their provider networks to ensure compliance with the Act's requirements. This could impact hospital-based specialties if certain providers are no longer included in insurance networks or if hospitals need to renegotiate contracts with specialists.

Administrative burdens – Compliance with the Act may introduce additional administrative burdens for hospital-based specialists. Ensuring transparency in billing practices, resolving disputes with insurers, and educating patients about their rights under the Act could require additional resources in the form of more staff or other new expenses.

Medicare reimbursement

Medicare reimbursement rates change annually due to legislative decisions, economic considerations, advancements in healthcare, and/or efforts to improve the quality and efficiency of care delivery. To ensure fiscal responsibility and meet the healthcare needs of its beneficiaries, by law Medicare must operate within its allocated budget. As a result, reimbursement changes can impact physician specialties differently every year depending on the mix of services they provide.

Declines in reimbursement for hospital-based specialties have included:

Anesthesiology – The PYA Compensation Study: Spotlight on Anesthesiology reports that, while the Medicare anesthesia conversion factor rates have varied, overall, the compound annual growth rate declined approximately 1% from 2019 to 2023.

Emergency medicine – An evaluation of Medicare reimbursement rates from 2000 to 2020 published in the *Annals of Emergency Medicine* revealed an average decrease of 1.61% each year.

Pathology – The *American Journal of Clinical Pathology's* retrospective review of pathologist professional Medicare Part B billings and payments from 2012 to 2017 reports an overall payment decrease of 3%.

Radiology – A study published in the *Journal of the American College of Radiology* using Medicare Part B claims from 2005 to 2021 indicates inflation-adjusted reimbursement to radiologists per beneficiary declined 24.9%.

Hospitalist medicine – From 2021 to 2024, Medicare reimbursement for one of four commonly used CPT codes decreased 20% while the others increased between 9% and 25%.

Hospitalist CPT codes

HCPCS Code	Short Description	2021 Medicare Pricing	2024A Medicare Pricing	Difference
99221	Initial hospital care	$101.19	$80.55	-20%
99231	Subsequent hospital care (low 25)	$38.38	$48.13	25%
99233	Subsequent hospital care (high 50)	$103.28	$115.26	12%
99238	Hospital discharge day	$72.23	$78.91	9%

Other impacts

Payer mix

Payer mix, or the proportion of patients covered by different types of payers, can impact medical revenue in numerous ways given variations in payer reimbursement rates, administrative complexities, timeliness of payments, and patient financial responsibility. Specifically, different payers may reimburse healthcare providers at different rates for the same services. Private insurance plans typically reimburse at higher rates compared to government payers like Medicare and Medicaid. A provider with a higher proportion of patients covered by private insurance, therefore, may generate higher overall collections.

Hospital-based specialties may see a disproportionate share of patients covered by government payers or self-pay patients since they are often contractually required to see patients regardless of the patient's payer.

Since each payer may have its own set of requirements and documentation standards for claims submission, dealing with multiple payers can increase the administrative burden and complexity for a provider. Additionally, the time it takes for payers to process and reimburse claims can vary. Providers who bill for a higher proportion of patients covered by payers with shorter reimbursement cycles may experience more consistent and timely cash flow.

Payer mix also affects the portion of healthcare costs that patients are responsible for paying out of pocket. Patients covered by private insurance plans may have lower copays, deductibles, and co-insurance compared to those covered by government programs or who are uninsured. Providers with a higher proportion of patients with better insurance coverage may have lower levels of patient bad debt.

Program Size

A key component to determining the amount of a subsidy package is understanding the number of providers needed to support the hospital or health system's services. This determination can be made by assessing factors such as the size of the hospital, case or patient volume, case complexity, operating room utilization, coverage model, staffing model, geographic location, teaching and research activities, and patient population characteristics, among others. For example, a smaller hospital may need fewer emergency room physicians to effectively handle the workload compared to a larger hospital that is also a trauma center, even though both require coverage around the clock.

Similarly, hospitals with a high volume of complex surgical procedures will typically require more anesthesiologists to provide anesthesia services. Hospitals with longer than average lengths of stay may require more hospitalists to provide ongoing care and management for patients throughout their stay. And hospitals with higher volumes of complex and diverse pathology specimens with rapid turnaround requirements may need more pathologists. Hospitals, therefore, must conduct a thorough assessment of their service requirements to determine the appropriate number of providers needed.

Provider supply and demand

AMN Healthcare's 2023 Review of Physician and Advanced Practitioner Recruiting Incentives lists radiology, anesthesiology, and hospital medicine as three of the top 20 most requested searches by specialty. In the report, search requests from 2017-18 to 2023 increased 17% for radiology and 248% for anesthesiology, and base salary or guaranteed income grew 4% for radiologists and 12.5% for anesthesiologists.

Similarly, in its report, Physician Workforce: Projections, 2021-2036, the National Center for Health Workforce Analysis indicated shortages for anesthesiology, pathology and hospital medicine are expected to reach 10%, 15%, and 23%, respectively, by 2036.

The only hospital-based specialty that may have a future surplus is emergency medicine (23%). This surplus is further supported by a study published in 2021 in the Annals of Emergency Medicine citing for the "first time in its history, emergency medicine is facing the likely oversupply of emergency physicians in 2030."

Higher demand for certain provider specialties may compel higher subsidies.

Subsidy payment structures

The most common subsidy payment models are a flat amount, generally paid annually and often subject to reconciliation, or a net collections guarantee. Which payment model is used depends on how a hospital guarantees revenue or reimbursement to a medical provider and the financial implications for both parties. The choice between these payment models depends on

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the priorities and risk tolerance of both the hospital and the provider.

Flat (or fixed) payment amount – With a flat payment subsidy structure, the hospital agrees to pay the medical provider a fixed sum of money based on the provider's estimated revenue and anticipated expenses.

This fixed amount can be determined based on various factors such as historical revenue, anticipated workload, services provided, and anticipated expenses including operating expenses and provider full-time equivalent staff and their corresponding fair market value compensation and benefits.

The advantage of this structure for the medical provider is financial stability as the provider receives a consistent payment regardless of fluctuations in revenue. If the provider's actual revenue is lower than anticipated, however, the provider assumes the financial risk since the revenue plus the fixed amount may not generate the total amount needed to cover fair market value provider compensation, benefits and operating expenses. If the provider's actual revenue is higher than anticipated, there is risk of overpayment from the hospital, potentially resulting in compensation above fair market value for the provider.

Net collections guarantee – With a net collections guarantee subsidy structure, the hospital guarantees a minimum level of revenue to the medical provider based on the revenue generated by the provider's services. Under this arrangement, the total revenue received by the provider is compared to a guaranteed minimum level of revenue. If the total falls short of the guaranteed amount, the hospital reimburses the medical provider for the shortfall.

To mitigate the potential risks associated with both payment structures, agreements often allow for a review of the provider's financials on a routine basis and/or include a provision to renegotiate the payment should the facts and circumstances of the situation change.

Key areas for review

Several key areas should be considered to effectively evaluate the appropriateness, compliance, and integrity of subsidies paid by hospitals to medical providers. (See Exhibit 1 – Physician Subsidy Review Checklist on the following page.)

Coverage needs and hours – The type and duration of coverage, specifically whether onsite or offsite via call coverage (i.e., unrestricted), should be determined and delineated. An arrangement may require one or both. Onsite coverage requires physical presence at the hospital for identified periods of time and unrestricted call coverage allows medical services to be provided remotely.

The different coverage requirements impact the determination of fair market value compensation in conjunction with other items such as productivity. Additional factors, such as anticipated weeks of vacation, can also affect the subsidy calculation. For example, depending on the weeks of vacation contemplated, more or fewer providers may be required, which affects overall compensation.

Provider productivity – Understanding productivity, as measured in professional collections, number of cases, American Society of Anesthesiologists (ASA) units, encounters, or work relative value units, among other measures, is critical to determining provider burden and ultimately to determining compensation.

For example, a pathologist may be needed 24/7 for urgent cases, such as intraoperative consultations or emergency autopsies, yet these services occur infrequently. The amount of compensation, therefore, may be different than if urgent cases occur frequently. Alternatively, some pathology cases may be more complex and time-consuming to analyze, requiring additional expertise and resources.

Complement of providers – Many hospitals use a team-based approach, involving both physicians and advanced practice providers. For example, anesthesia programs often use anesthesiologists, nurse anesthetists, and/or anesthesiology assistants. Radiologists may use advanced practice providers to assist with interventional procedures. The specific mix of providers and how each provider is used should be known to understand the resulting financial impact.

Revenue cycle performance – Effective revenue cycle management is essential for the financial health and success of a medical provider. This includes but is not limited to accurate coding and documentation, timely claims submission and follow-up, accounts receivable management, and patient billing and collections activities.

Exhibit 1 – Physician subsidy review checklist

Focus area	Supporting considerations/materials
Purpose of the subsidy	Review documentation of need for financial assistance such as provider needs assessment
Documentation of arrangement	Review agreement between hospital and medical provider including the terms, conditions, and intended use of the funds
Payment structure	Review contract or agreement to understand payment structure
Payer mix	Calculate gross charges by individual payer as a percentage of total gross charges and compare to available benchmark data
Provider complement	Review number of full-time equivalent (FTE) providers needed based on coverage requirements, anticipated volumes or caseloads, and required mix of provider FTEs (e.g., physicians, nurse practitioners, physician assistants, certified registered nurse anesthetists)
Coverage requirements	Identify the coverage requirements (i.e., onsite, offsite) to service the agreement and fulfill the hospital's needs Reconcile anticipated coverage needs with actual coverage provided
Financial metrics: Professional collections Adjusted or net collection ratio (ACR) Days in A/R Operating expenses	 Determine professional collections generated by providers for the services applicable to the agreement and compare to available benchmark data Calculate ACR and compare to available benchmark data Calculate days in A/R and compare to available benchmark data Request regular financial reports from the provider (i.e., provider's financial statements or other relevant documentation) to evaluate applicable expenses and use of subsidy funds, and compare to available benchmark data
Provider compensation	Determine if provider compensation used in calculating the subsidy is consistent with fair market value and commercial reasonableness
Use of funds	Ensure funds are used for their intended purpose and in accordance with the terms of the agreement and are not diverted for nonqualifying purposes
Reconciliation of compensation	If the agreement has a reconciliation requirement, ensure payment reconciliations have occurred or are occurring according to the agreement
Payment comparison	Compare total amount paid to the medical provider to the allowable amount in the contract

The hospital should not subsidize poor business practices.

While a hospital can subsidize a medical provider because the provider cannot bill and collect enough to cover fair market value compensation and operating expenses, the hospital should not subsidize poor business practices. For example, if a provider requests financial assistance but is inadequately tracking outstanding claims, is not identifying and resolving unpaid or underpaid claims, or is not implementing strategies to reduce accounts receivable (A/R) aging above industry norms, a subsidy may not be warranted. Best practices to mitigate ineffective revenue cycle management include regularly monitoring and analyzing key financial metrics and performance indicators to ensure the amount of subsidy is reasonable.

Provider expenses – In a subsidy arrangement between a hospital and a medical provider, the expenses covered can vary depending on the terms of the agreement negotiated between the parties. The most common expenses that may be covered:

- Operating expenses – Subsidies may cover a portion of the medical provider's overhead, including rent or lease payments for office space, utilities, facility maintenance, and other costs associated with operating the provider's practice. Subsidies may also cover professional liability insurance, and costs associated with administrative overhead, regulatory compliance, risk management, and legal services.
- Personnel costs – Subsidies may be used to cover salaries, wages, and benefits for physicians, advanced practice providers, administrative staff, and other personnel who perform the identified services or support those who do.
- Technology and equipment – Subsidies may support the acquisition, maintenance, and upgrade of medical equipment, technology infrastructure, electronic health record systems, and other tools necessary for delivering patient care and operating the provider's practice efficiently.

Hospitals and medical providers should clearly define the scope of expenses covered in the subsidy arrangement and establish mechanisms for tracking and reporting subsidy expenditures to ensure transparency, accountability, and compliance with regulatory requirements.

Conclusion

Subsidy arrangements between hospitals and providers involve complex considerations to ensure medical services are adequately funded while meeting quality and regulatory standards. A systematic and detailed review of subsidy arrangements can provide an organization with the information needed to proactively identify potential risks, assure regulatory compliance, and safeguard an organization's finances to allow for the provision of critical medical services. **NP**

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